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Indian Child and Family Services
Kinship Care Program
Final Evaluation
October 1, 2000 to September 30, 2003

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EXECUTIVE SUMMARY

A. Provide General Overview of Program/what was implemented and why.

ICFS Kinship Care Program was designed to provide four types of services to American Indian kinship caregivers and for children who are in their care. The services were identified as those that could help American Indians in an urban setting:

1. Gain custody of their relative children who had been removed from their biological parents and were in the foster care system in the Los Angeles/Orange county area.
2. Help them gain or improve skills that would allow them to keep the children in care with a minimum of disruption of placements.
3. Help them to achieve a stable, long-term plan for the child(ren) within the family—resulting in adoption or guardianship.

The services offered and implemented included:

1. **Treatment** - using combinations of individual, conjoint and family counseling. The treatment services were available to the children and the caregivers. The services were designed to help children needing intensive therapy, including sexual abuse counseling. Kinship care providers were offered counseling to help them understand what the children were experiencing and how their behaviors might be reflecting what happened to them. Counseling was provided in the home of the family or in the child's school. Treatment plans were developed for the children individually and for the family. Because the county has jurisdiction in child welfare matters, we reported on a regular basis to the county social worker or to the Judge at Children's Dependency Court for each of the children we served.
2. **Court Advocacy** – this service included court-related services to the children and their kinship caregivers who were in the court process. Services included accompanying families to court, providing transportation and support to the family and working with the court to insure that families had the opportunity to take their relatives into care.
3. **In-home Support** – the program team (Coordinator, Counselor, Caseworker and Health Counselor) made assessments of each family to determine which services were most needed. Weekly (more often, if needed) visits were made to the home to discuss with the caregiver problems that might be occurring in the child's adjustment to the family. The Caseworker or Counselor assisted families in making appointments with school personnel to insure that the child's educational needs were being met. The Health Counselor made assessments of the families medical needs and helped find referrals and transportation. While in the home members of the team gave tips on good

parenting, in some cases demonstrating or modeling good parenting behaviors. Providing supervised recreational activities and outings for the children provided respite care to the caregivers. The events proved to be fun for the children and gave staff an opportunity to see the children in an informal atmosphere. The caretakers benefited by having time to themselves.

4. **Individualized In-home Parent Training** – was provided to the caregivers emphasizing the developmental needs of the relative children. We also provided in-home health and safety training including home safety checks. The in-home parent training was provided by the Counselor and Caseworker and was similar to that provided to our foster parents. The training was to assist the Kinship caregivers to become child care experts. Emphasis was placed on the developmental needs of children and particularly children who have been abused or neglected. The Health Counselor provided health and safety training to insure that the homes were safe for children and that the caregivers were trained in good nutrition and how to create a healthy lifestyle for children. The program team also provided smoke detectors, baby-safe locks, car seats and conducted home safety checks.

B. Focus on Results and Lessons Learned

In general, the results achieved were those we expected. Because of the many years of experience in working with this unique population in the urban Los Angeles setting, we felt that the services we designed for this project would gain good results. We will go into greater detail in the body of the evaluation when talking about the services and how clients of this project used them.

In general, the results achieved were those we expected. Because of the many years of experience in working with this unique population in the urban Los Angeles setting, we felt that the services we designed for this project would gain good results. We will go into greater detail in the body of the evaluation when talking about the services and how clients of this project used them.

The lessons learned were that clients needed most of the services long-term, some clients stayed with the program for the entire 36 months of its duration. Some of those who came into the program in the second or third years are continuing to receive services from other funded programs in our agency. They are not, though, receiving the exact same mix of services.

Typically, clients would come to us because they needed help in the court advocacy part of the program. They were trying to get custody of their relative children who were in the system and they were experiencing difficulty in accomplishing this end. Having gained custody of the children with our help, the families began to use the other services, the counseling, in-home support and individualized parent training. Many of the families had been so focused in their fight to gain custody, they hadn't considered what the children had gone through prior to being removed from their parents, and since their removal as they went from foster home to foster home. Many of the families weren't prepared for the behaviors the children began to exhibit or for the school problems and other problems that surfaced as the children began to

take their place in the new family structure. These behaviors had the potential to disrupt placements.

These families continued to be impacted by crisis after crisis, such as adult children returning home, oftentimes with children of their own, other children joining the family, job loss, and separation or divorce. There were other practical matters such as adequate housing and unexpected emergencies such as illness of the caregivers and even death that also threatened placements.

CHAPTER I. - INTRODUCTION

A. Background Information

Indian Child and Family Services (ICFS) who implemented this project, is a program of Southern California Indian Center, Inc. (SCIC), a 501 (c) (3), non-profit agency serving the American Indian population in Los Angeles and Orange counties. ICFS had been receiving requests from clients who were trying to gain custody of their relative children who were their grandchildren, nieces or nephews, siblings or cousins. ICFS did not have an array of services for these clients to help them not only gain custody of the children, but help them to keep the children in placement and help them make long-term plans for them.

When we saw the announcement from the Children's Bureau for Kinship Care services, we designed the types of services we felt would aid families in securing beneficial long-term placements for the relative children and we applied for funding. We were excited when we received word we were funded and would have an opportunity to see if the array of services we selected would in fact help families to gain custody of their relative children, help keep them in placement without disruptions and would result in appropriate long-terms plans for the children.

B. Program Model

a. Collaborative efforts

Although ICFS was not part of a collaborative in implementing the Kinship Care Program, we do maintain close working relations with the following: the Los Angeles County Department of Children and Family Services, especially the Indian Unit; and with personnel in the American Indian courtroom in Edelman's Children's Court; and with Indian and non-Indian churches, schools and social service agencies throughout the county. We receive many of our referrals from the above-mentioned agencies and programs and we refer many of our clients to them as well. ICFS is well recognized in the community because we have been in the community since 1986 and because of the excellence of the services we provide to our clients. We do acknowledge and recognize that we need the network of agencies and programs with whom we work in order to be able to insure our clients receive all the services they need in as timely a manner as possible.

b. Special issues (e.g. unique community characteristics)

The American Indian community is unique in many ways. For the purposes of this program that which is most unique is the fact that special federal legislation was enacted in 1978, The

Indian Child Welfare Act, because Indian children were being removed from their parents and communities at an alarming rate, four times higher than any other group in the country. One of the requirements of the Indian Child Welfare Act is that when Indian children are removed from their parents the first order of preference for out of home placement is with a relative, or in other words, a kinship care placement.

One of the special characteristics of the Indian community is that most tribes do not believe in "termination of parental rights", usually a precursor to adoption. They do not believe that this is a relationship that can be broken or set aside by a legal act. Perhaps this is because the relationship is not a matter of nuclear families, but because the relationship encompasses extended family, clan relationships, societies within the tribe, such as medicine people or healing societies, warrior societies, religious societies and so forth, in other words, the whole community. Many tribes do practice "customary" adoptions that do not include terminating the relationship with the biological parents and that continue to be considered as not true adoptions by most non-Indian courts and child welfare agencies. For most tribes, guardianship is the preference. It has the stability and long-term effects of adoption without the requirement of sundering the child-parent relationship. This does not mean that the parent(s) have inappropriate access to the child. Most tribes, traditionally or by custom, had practices to allow them to take care of children who had lost their parents to death or abandonment, or where the tribe considered the parents unfit to rear their children. This is known as "customary adoption". There is an upsurge in implementing this traditional way of caring for children within the American Indian community and of achieving recognition for customary adoption so that adoptive parents may be eligible for services when needed.

This issue of the unacceptability of "termination of parental rights" and "legal" adoption by another family or non-family member in the Indian community is the most difficult to try to explain to county social workers, judges and others involved in Indian child welfare cases.

Another unique characteristic is that the American Indian community with which we worked has historically been in the lowest 25% in terms of family income. These families live in what can only be described as abject poverty. This lack of financial resources was one of the greatest stumbling blocks to achieving stability and permanency for children in kinship care. Oftentimes, in the course of providing services families would be thrown into crisis, either they would be evicted from housing because they could not pay the rent and became homeless for a period of time. Most often they would move in with relatives into homes that were considered substandard by county social workers and/or were already overcrowded. In many cases adult children with children of their own moved in with the caregivers because they were homeless. Again, space was an issue and caused problems with county social workers. Any situation involving finances that came up in the family and was unexpected was cause for crisis. Poverty affected every aspect of family life, from inability to purchase clothing for school—some public schools require children to wear uniforms to class, to transportation to doctors, dentists, or other appointments. Poor health of caregivers was exacerbated by the lack of finances, often times leading to non-compliance for health treatment, especially purchase of needed medications. There was, of course, no money for any type of recreational or educational activities for the children.

Our experience in implementing this program and providing services to this unique community demonstrated to us that these families were literally battered by stressors. Families would no sooner recover from one crisis than another would strike. Often times it felt as if they were being dealt blows. Despite the often devastating circumstances faced by these families they remained steadfast in their desire to stay together. Caregivers considered that their relative children would be with them until they were grown and on their own. They didn't ask for the children to be removed. Also unique in this community was the caregiver's belief that the children were fine just as they were. This some times made it difficult to provide counseling services.

c. Funding information

ICFS was funded by the Children's Bureau for 3 years for $200,000.00 each year. The funding was sufficient to implement the program for the number of clients we stated we could effectively serve each year. We met our required match in funding through grants from private charitable foundations. In addition we provided additional services to some clients that were not covered by funds from the Children's Bureau. These services were paid for by the parent organization, SCIC and included legal services and emergency food and clothing, assistance in finding housing, jobs, and assistance in getting medical services.

C. Overview *of Methodology*

The methodology we implemented was simple. We began with this statement of the problem as we perceived and experienced it. "The lack of supportive services for American Indian kinship caregivers inhibits American Indian children from achieving permanency with family members who have similar cultural backgrounds and compromises the physical and psychological well-being of American Indian children."

This statement discloses the underlying assumption that providing American Indian children in kinship care and their kinship caregivers with an array of culturally appropriate supportive services will enhance the stability of kinship placements and increase the safety and well-being of American Indian children in kinship care.

We then designed the array of culturally appropriate services that we felt would address the problem statement and the underlying assumption that these services would achieve stable kinship placements, increase the safety and well-being of the children in care and would help achieve permanency in placement.

The Objectives and the specific services will be addressed in the implementation portion of the evaluation.

We provided the services to our clients, both children in kinship care and their caregivers as described in our objectives. We implemented the activities as described for each of the objectives. We documented the number of clients served each year. We documented the services provided to them and we documented the progress of the individual children served, the caregivers and the family as a whole.

The data gathered from the documentation was compiled and analyzed to ascertain if, in fact, the services provided had the expected effect and achieved the expected outcomes. This final evaluation is the expression of the methodology.

CHAPTER II – PROCESS EVALUATION

I. Implementation Objective No. 1

ICFS started providing services immediately upon receiving the contract from DHHS. Kinship Care providers were identified from among the community and were informed of services available to them. Flyers were developed and handed out at events such as Pow-wows and were advertised in the parent program's (Southern California Indian Center, Inc.) newsletter. Referrals were also received from the Los Angeles County Department of Children and Family Services and the American Indian courtroom in Edleman's Children's Court.

A. Statement of first Implementation Objective

Each of the objectives, although providing a separate and distinct service, was meant to be part of an array of services that constituted a whole. It was this particular array of services that we felt would achieve the expected outcomes. As such, we will describe whether we had success/effectiveness in attaining each objective and then address the remainder of the questions, i.e., research questions to assess implementation of the objectives, findings that relate to the research questions, barriers and or facilitators and lessons learned, for the combined objectives.

OBJECTIVE A: Provide direct, face-to-face treatment to 35 children in kinship care and who are suffering the effects of abuse/neglect using combinations of individual, conjoint, and family counseling.

Success/effectiveness in attaining this objective A:

Year 1	Year 2	Year 3
Children - 35	35	35
Adult Caregivers - 18	21	20

We were successful in all three years in meeting the numbers of clients we estimated we could serve. In year one we met our goal of providing face-to-face treatment to 35 children in kinship care, although we were not required to provide statistics on the number of caregivers served, we also served eighteen of them. In year 2 we met our goal of serving 35 children and we also served 21 adult caregivers. In year 3 we served 35 children and 20 caregivers.

OBJECTIVE B: Provide court-related services that assist 35 children in kinship care who are in the juvenile court process and 20 or more of their kinship caregivers.

Success/effectiveness in attaining this objective B:

Year 1	Year 2	Year 3
Children - 35	35	35
Adult Caregivers - 20	21	20

We met our goal in providing services to 35 children and 20 or more kinship caregivers in each year of the grant. This service was important because, in many cases, this service was the entry point into the kinship care services available to clients. They came to us seeking help in retrieving their relative from the child welfare system. In most cases they were experiencing difficulties, because either they did not understand the child welfare system or did not understand the dependency court system. There was also bias exhibited by county social workers against Indian grandparents. Had we not provided advocacy and support to the grandparents they would not have succeeded in gaining custody of the children. Families needed the advocacy services we provided.

OBJECTIVE C: Provide in home support, for 35 children in kinship care and 20 or more kinship caregivers, including support in attaining Individualized Education Plans where needed, referrals to community agencies, modeling of parenting behaviors, recreational activities, and day-time respite.

Success/effectiveness in attaining this objective C:

Year 1	Year 2	Year 3
Children - 39	44	35
Adult Caregivers - 21	26	20

We met or exceeded our goals in this objective in each year of the grant. It was interesting to us that this service was the one most used by our clients. We have long believed in the importance of in home support and providing of recreational activities for the children. Our staff supervised all activities for the children. The activities also provided day-time respite for the adult caregivers. The recreational activities are healthy for the children exposing them to wholesome activities that many of them have never before experienced such as attending movies or plays, attending cultural events such as Pow-wows, going to the zoo or attending appropriate spectator sports. The adult caregivers get a break from parenting children who oftentimes have difficult behaviors with which to contend, brought on by abuse, neglect and separation from biological parents and siblings.

OBJECTIVE D: The Program will provide 20 or more American Indian kinship caregivers individualized, in-home parent training, emphasizing the developmental needs of the relative children in kinship care and will provide in-home health and safety training including home safety checks.

Success/effectiveness in attaining this objective D:

Year 1	Year 2	Year 3
Adult Caregivers - 20	24	20

We met our goal in providing services described in this objective in each of the three years of the grant. This objective was important because these services helped stabilize the families and allowed families to "brush up" on child rearing skills, or gave them appropriate skills in order to keep their relative children in care. These services were designed following the training we provide to our certified foster families and closely followed the training we developed for them. We found this helped when working with county social workers and with

the courts. We were able to avoid deficiencies being found in the home or correct them when they appeared in a manner acceptable to the county workers and the court, thus avoiding disrupted placements.

We experienced no difficulties in meeting our objectives. We had an adequate number of clients to serve and were able to provide them the services described in a timely fashion. When the program ended we were still serving clients and we continued to receive referrals. We moved many of the clients to others of our funded programs where they can continue to receive services, though they may be more limited in nature.

A. Research Questions to Assess that Implementation Objective

The research questions we had were two in number.

1. The first question was whether the array of services we designed for this program would achieve the expected outcomes.

2. The second question was whether in the course of implementing the program we would find we needed additional services not included in the original design.

B. Findings that Relate to Research Questions on Implementation of Objectives

1. Success/effectiveness in attaining each objective.
This question has been answered for each of the objectives in Section A. Statement of first Implementation Objective. Please refer to that section.

2. Barriers and/or facilitators.
The barriers we experienced in implementing the program were the following:

- county social workers were extremely biased against Indian grandparents gaining custody of their grandchildren;
- relationships with county adoption workers were negative or destructive;
- poverty was a barrier in that grandparents often did not have the funds to provide educational and recreational activities for the children, and taking children into their home caused crowded conditions that were frowned upon by the county social workers;
- school personnel were unsupportive;
- the court often demanded adoption against the wishes of the family;
- lack of reliable transportation either personal or public had a negative impact on families efforts to access resources; and,
- intrusion into the family of additional family members in need.

The advocacy and providing the array of services we designed aided the grandparents in gaining custody of their grandchildren. The support services we provided helped them to keep the children once they gained custody. All-in-all, clients came to us for services and we had the staff and materials to effectively work with them in a timely fashion.

Facilitators were:

- our knowledge of the community we were serving;
- highly qualified staff who were either American Indian themselves or who had worked in and were know in the Indian community;
- services were provided in a culturally sensitive and competent manner;
- we had access to additional services from the parent agency, not covered in our funding structure;
- the network of agencies to whom we refer and who refer to us was available to us;
- staff committed to the belief that children do better within their (extended) family; and,
- gained the support of three foundations who were willing to provide the matching share for this project.

3. Lessons learned

We suspected there was a need for Kinship Care services in Los Angeles and Orange counties. In implementing the program we found that the need was great. We also found that the level of problems facing the families was greater than we expected and in many cases required a prolonged period of service delivery.

The numbers documented in the objectives portion of this evaluation were individual counts of children and caregivers served. We thought it might be of interest to the Children's Bureau to see the age and sex of the caregivers and that of the children they cared for as the following will show.

Relationships of the identified caregivers were as follows: **22** were identified as being the **grandmothers** of the children. Their **median age** was **59.36** years of age. Three **(3)** were identified as being form **40 - 49** years of age**, 8** were from **50 - 59** years of age, **8** were from **60 – 69** years of age, **2** were from **70 – 79** years of age and **1** was from **80 – 89** years of age. Nineteen (**19**) of the grandmothers were **50 years or older**, while **3** were **younger than 50**. Three (**3**) **grandfathers** were identified as caregivers as well although they were not sole caregivers, they were married to the grandmothers identified above. The grandfathers were **59, 69, and 79** years of age.

Other caregivers identified were as follows:

- Sisters caring for their siblings – 2 were identified and each was 21 years of age;
- Cousin – 1 Cousin was identified and she was 38 years of age;
- Aunt – 3 Aunts were caring for their nieces or nephews and they were 32, 35 and 36 years of age.
- Grand Aunt - 1 Grand Aunt was identified and she was 46 years of age.
- Grand uncle – 1 Grand Uncle, married to the 1 identified Grand aunt was identified and he was 53 years of age.
- Great Aunt – 2 Great Aunts were identified and they were 46 and 57 years of age.

The above numbers are reflective of national statistics that show that kinship caregivers, especially grandparents tend to be older, tend to live on fixed or limited incomes and tend to have a high rate of chronic, debilitating illnesses. Because of these factors these caregivers need an array of supportive services in order to maintain their grandchildren in care. Generally speaking, the **other** category of caregivers tended to be younger than grandparents ranging in age from **21 to 57 years of age**. They too needed the services, especially the very young siblings caring for siblings, and the other caregivers, some because of their age, some because the kinship was not as close as with the grandparents and siblings, and with all, because of the poverty and attendant lack of resources the families had to confront on a daily basis.

We felt it important to also note the ages and sex of the children that were served by the program.

AGES	MALE	FEMALE
0 –1	1	5
2 –5	8	6
6 – 10	7	14
11 – 15	16	12
16 - 18	4	4
Total served:	**36**	**41**

The majority of the children were between the ages of 2 and 15 with the bulk of them being between the ages of 6 and 15. One male was newborn and 5 females were newborn to 1 year of age. In the 16 to 18 years of age category we served 4 males and 4 females. Most of the children fell into the age group where most foster parents will not take children into care, children 10 years of age or older. This is also the age when children begin to exhibit difficult behavior problems and all the issues that arise in puberty, especially in those children who have been physically, sexually and emotionally abused.

It was clear to us, looking at the very low levels of disruption experienced by our families, that there was a strong intent on the part of the caregivers to keep the children in care and to work through behavior and other difficulties with the assistance of our staff and the services we provided.

We also gathered data by number of families served. We counted 32 families that received services over the three-year period. Of those families one came to us through referral, we conducted an assessment and had a plan for services to be provided. Before the services could begin the placement fell apart and the clients exited the program. Of the remaining 31 families the following data was gathered.

# OF FAMILIES USING SERVICES	# OF MONTHS SERVICES PROVIDED
1	1
2	2
4	3

1	6
1	7
1	8
3	9
2	15
1	23
3	24
1	27
1	28
2	30
7	36

Of the 31 families, 17 required 15 to 36 months of services while 13 required from 1 to 9 months or less than one year of services. This data is not complete because some of the families that came into the program near the end of the second year or in year 3 are still receiving services after the program ended.

Services were used by the families in the following manner:

Service	**# of Families Served**
Court Advocacy	21
Counseling	22
In-home Support	30
School Advocacy	20
Referrals	12
Modeling Parenting Behaviors (parenting skills)	19
Recreational Activities For Children	23
Day-time Respite	23
In-home Parent Training	12
In-home Health & Safety Assistance	13
Other (see list of other services used)	21

All 31 families used more than one service while they were part of the program. The service most used, by 30 of the 31 families, was the In-home support, Recreation Activities for children and Day-time Respite for the caregivers was the next most used service, used by 23 families. Twenty-two (22) families used the counseling services, 21 used Court Advocacy and Other services, 19 used Modeling Parenting Behaviors (parenting skills), 13 used In-home Health & Safety services and 12 used In-home Parent Training.

Typically, although not always, clients would come into the program seeking the court advocacy services first and then, once the children were in placement and problems began to emerge, they availed themselves of the other services.

The Other Services category consisted of referrals to our network of public and non-public agencies and programs for services we do not provide and were the following for the 31 families:

Child Psych Clinic For Meds.
Indian Boarding School
Additional Counseling
Medical Services For Child Needing Surgery And Meds
Tribal Information
Kinship Medical Services
Senior Services
After School Activities
Mentoring For Children
Residential Treatment
Health Services
Fair Housing
TANF Child Care
Referral To Regional Center
Educational Services
Adult Day Treatment
Asthma Clinic

All of the referral services were needed to help stabilize the family in order to keep the children in placement or to prevent disruption of the placement.

ICFS also provided services not paid for by DHHS funds, but were services paid for by the parent organization, Southern California Indian Center, Inc. or by other programs administered by ICFS and that were necessary to carry out the goals of the program. These services included:

SERVICE PROVIDED	# OF FAMILIES USING SERVICE
Purchase clothing for children	18
Transportation to Dr's Appointments	7
Reading mail/documents for illiterate caregiver	1
Purchase Holiday Food	5
Emergency Food	1
House cleaning & laundry	1
Facilitate sibling visits	1
Tribal enrollment assistance	1
Purchase school supplies & books	1
Financial assistance	1

Some of the services were one time only, others were services provided on an on-going basis.

In response to Research Question # 2, ***whether in the course of implementing the program we would find we needed additional service not included in the original design in order to achieve our outcomes,*** and as the above data shows, it became clear that we did need additional services and resources. We were fortunate that our referral network was responsive to client needs and also that we had the ability to use staff to transport clients to referral services and to advocate for clients until they actually began to use the referral services. We did this in an effort to insure that families would not "fall between the cracks" between referral and the receiving of services. We were also fortunate that the parent program, SCIC, had additional resources of which we could take advantage.

Should we have the opportunity to design a program such as this in the future we would add increased funding in order to be able to provide some of the additional services through the

program, although not referral services. We would continue to use the resources of our network with the exception of the mentoring services.

We would add another component to the program, mentoring services for the children. This service is important because many of the children come to us below grade level in school and with low self-esteem. The mentoring program addresses both of these issues with the children and leads to improved school performance and more appropriate behavior at home, which leads to increased stability of the placement.

CHAPTER III. – OUTCOME EVALUATION

ICFS identified three expected outcomes resulting from services provided in primarily an in-home setting by American Indian practitioners or by practitioners familiar with American Indian customs and traditions and who were known and accepted in the American Indian community.

1. Outcome number one was to increase the stability of American Indian children placed in kinship care compared to stability prior to program implementation.

We were not able to gather baseline information regarding the stability of American Indian children in kinship care placements prior to implementing the ICFS Kinship Care Program. We did know that Los Angeles County was placing American Indian children in kinship care, granting legal guardianship and providing no services to the families. Clearly this was a prescription for failure. We also knew that it was oftentimes difficult for families to gain custody of their relative children because the mandates of the Indian Child Welfare Act were not being followed and because so many American Indian families in the urban Los Angeles area live in poverty and their homes are often viewed as substandard by county social workers. We also know that the National Resource Center for Foster Care & Permanency Planning, which is funded by the Children's Bureau/ACF/DHHS in its *Tools for Permanency, Tool #4: Kinship Care, states, "Placements with relatives have been less likely to disrupt and tend to last longer than non-relative placements* (George, 1990; Testa, 1992, 1993; Wulczy & George, 1992). We have no reason to believe it would be different for American Indian children than for the general public. In addition, in Los Angeles County, when Indian children are not placed in kinship care the chances of them being placed in a licensed Indian foster home are next to non-existent. ICFS is a state licensed Foster Family Agency recruiting, training and certifying American Indian foster homes. We are experiencing the same lack of interest in those willing to foster as are other private state licensed agencies and the public agencies administered by Los Angeles and other counties in California. There are many more children needing foster care than there are people willing to foster.

Non-kinship, non-Indian foster care for American Indian children is not only out of compliance with the Indian Child Welfare Act, which mandates that the first order of placement when children are removed from their parents is with a relative (or kinship) caregiver, but that generally known and accepted information regarding foster care placements reveals that most children in foster care experience multiple placements in multiple foster homes.

In terms of stability for the children in kinship care and whom the ICFS Kinship Care Program served, our documentation reveals the following:

Of the 78 children that were served in the course of the 3 year program 4 children had disrupted placements. One of the children went into a Residential Treatment Facility, one went back into foster care, one went to Probation Camp within the Juvenile Justice System and one went back to Oklahoma and we did not know what type of placement the child went into.

An additional 4 families caring for a total of 12 children, sometime during the course of the program withdrew from or refused services. We do not know if any of these placements disrupted, another 2 families with a total of 6 children in kinship care moved out of our service area and we were unable to follow-up with them. The remaining 56 children continue in kinship care placements placement with no disruptions.

This chart illustrates that the number of stable placement was indeed high at 71.80%, substantiating that the array of services that were provided by the ICFS Kinship Care program did achieve the expected outcome of stable placements with few disruptions.

	#	%
Number & % of children whose placement disrupted	4	5.13%
Number & % of children whose caregivers withdrew from or refused services	12	15.38%
Number & % of children whose caregivers moved from service area	6	7.69%
Number & % of children remaining in stable placements	56	71.80%
	78	100%

2. Outcome number two was to increase safety of American Indian children placed in kinship care compared to safety prior to program implementation.

Safety of children in the home was a major concern of the ICFS Kinship Care Program. That was one of the reasons we designed the services so that many of them were delivered in the home. This meant that our workers were in the home a minimum of once a week and oftentimes more than that. We also conducted safety checks of the home to insure the homes met standards similar to those in certified foster homes. We insured the homes had fire alarms, baby safety locks for cupboards and other safety implements. We also checked the homes for cleanliness and aided the families in acquiring needed furniture, clothing, food, medical care and other services that made the homes safe.

Although we did not have a baseline of child safety prior to implementing the program, in the 3 years we provided services the following occurred. Of the 31 families we served we had only one family where one child was removed from the paternal aunt because of a child abuse report made to the county social worker. The child was removed, went into a county foster home for a short period and was then placed with a maternal aunt where the child remains.

Ninety-nine (99) percent of the children we served were in **stable, safe placements** with their kinship caregivers throughout the course of the program.

3. **Outcome number three was to demonstrate the enhanced well-being of American Indian children and their kinship caregivers compared to their well-being prior to program implementation.**

We felt it was important to describe the types or categories of presenting problems that the child(ren), the caregivers and the family as a whole encountered as they came into the program. These problems and the methods used to alleviate or overcome them were the basis of the services we provided. Following are the categories of presenting problems or identified issues for each of the program years for the child. It should also be noted that there was frequently more than one problem identified for a child of equal severity and needing intervention and services.

Categories of Child(ren's) Presenting Problems

Categories of Problems	**# of children with prob. Yr. 1**	**Yr. 2**	**Yr. 3**	**Totals**
1. School problems—acting out, truancy, learning disability, special ed., etc.	21	20	21	62
2. Behavioral problems at—school, home, suicidal, low self-esteem	14	14	18	36
3. Health issues	5	4	3	12
4. Child picked on by siblings	5	7	4	16
5. Loss and grief work	12	10	12	
6. Retrieve child from non-Indian placement, group home, juvenile detention	6	5	6	17
7. Help child with fear about caregiver's illness	1	1	1	3
8. Adjustment to kinship care placement, caregivers & school	11	8	8	27
9. Death of caregiver	1	1	1	3
10. Fear of parent (threats)	1			1
11. Child fears removal from kinship caregiver	3	6		9
Added Year 2				
12. Child moved to new city & school, adjustment probs.		1	3	4
13. Children have issues re: abandonment by parents		11	16	27
14. Child needs help with independent living skills		1	3	4
15. Child misses siblings, wants visitation		5	7	12

Added Year 3				
16. Children need extra-curricular activities, caregivers can't provide			15	15
17. Help child communicate feelings			12	12
18. Sibling rivalry issues			12	12
19. Child needs help to increase self-esteem and cultural awareness			20	20

By far the most encountered problem for the children was Category # 1 with 62 responses over the 3 year period and addressing issues around school including acting out at school, truancy, refusal to go to school, children with learning disabilities and children needing special education services. Problems at school often spilled over into the home causing difficulties in adjustment to the new home setting and causing difficulties with caregivers not knowledgeable about advocating for the children with the school system. The component of our program, School Advocacy was an appropriate and much used service for the children we served.

The next most encountered problems areas were Category # 2, behavioral problems at school, home and low self-esteem with 36 responses, and Category # 8, adjustment to kinship care placement, caregivers & school with 27 responses. There is some over-lap between, these three categories. The issues had to do with children entering into kinship care and the adjustments that come with a new environment. In addition children were going into new schools and classrooms. Most children came from chaotic environments where the parents did not require school attendance; so most children were below grade level and having difficulties with school work and with regular attendance. Most of the children suffered low self-esteem because they were behind in school and felt a great deal of frustration resulting in acting out and continued truancy. Some of the children also had undiagnosed learning disabilities and some needed special education classes. Adjustment to kinship care was also a problem in that most children had no experience with keeping schedules, and were used to chaotic living situations with no rules to follow. There were also situations where children of the caregivers felt displaced by their relatives who came into placement in their home. Category # 13, children confronting feelings of abandonment by their parents with 27 responses, was a problem faced by many of the children and also contributed to loss and grief issues and issues of self-esteem. Staff provided therapeutic counseling services to the children.

The forth most encountered category was # 6, retrieve child from non-Indian placement with 17 responses. Court Advocacy was the method of intervention in this category with staff attending court hearings and interfacing with county social workers in behalf of kin wishing to take their relatives into care. Category # 11, child fears removal from kinship caregiver received 9 responses. For these children this was a real concern. Once they adjusted to their new caregivers, home, school and routines, they were afraid that they would be removed and placed back into foster care. It was an issue that was worked through with the children, the caregivers and the family as a whole.

Categories # 5, loss and grief work with 34 responses This number reflects that woven through all the problems is the underlying issue of loss and grief, in some cases tremendous

loss due to death and abandonment and the grief that comes from the losses. The remaining responses were more individual in nature and were responded to by appropriate services to the children.

Categories of Caregivers Presenting Problems
We also felt it necessary to note the types or categories of presenting problems of the caregivers. They follow.

Categories of Problems	**# of caregivers with prob. Yr. 1**	**Yr. 2**	**Yr. 3**	**Totals**
1. Caregiver critical of child	5	5	6	16
2. Caregiver has difficulty dealing with child's anger	3	5	6	14
3. Caregiver has inadequate parenting skills, lacks knowledge of child development	7	10	12	29
4. Caregiver lacks involvement with child's progress at school	6	6	7	19
5. Caregiver requests counseling for child	7	6	8	21
6. Caregiver is concerned re: child's school progress, special needs	11	8	7	26
7. Caregiver seeks legal help for: custody, guardianship, adoption	7	7	8	22
8. Grief work	5	7	6	18
9. Health issues, caregiver or child	11	11	9	31
10. Caregiver threatened by child's parent	1			1
11. Caregiver overwhelmed by child(rens) needs, emotional, etc.	7	5	7	19
Added Year 2				
12. Caregiver & children adjusting to new household.		5	5	10
13. Encourage caregiver to allow sibling visits		3	3	6
Added Year 3				
14. Caregiver concerned re: unstable living conditions			6	6
15. Caregiver concerned re: whether parents will properly care for children after reunification			3	3

The presenting problems of the caregivers presented an array of areas of difficulty. The problem most identified by caregivers and staff was Category # 9, health issues of caregiver or child with 31 responses. One of the factors used as a reason for not placing children with grandparents is their advanced age and the medical and health problems they suffer. This was

true with some of the caregivers we served. Some had chronic and debilitating illness that impacted them and also impacted the children, who worried about their grandparents and worried about where they would go should they become too ill to

Health Advocacy was a needed and used service provided to both caregivers and children. The category with the next highest number of responses was Category #3, the caregiver has inadequate parenting skills and lacks knowledge of child development, with 29 responses. Most of the caregivers were grandparents with a median age of 59. As already noted, many were in ill health as well. The challenge of taking on grandchildren, often in sibling groups and often from more than one adult child was daunting. Many of these caregivers were raised in government boarding schools and lacked the role-modeling of positive and appropriate parenting skills that are usually gained in the home within family. We worked with the caregivers to provide positive Indian parenting, modeling behaviors and working with caregivers on child development.

The next most prevalent problem was described in Category # 6, caregiver is concerned regarding child's school progress and special needs, with 26 responses and reflects the most prevalent problem in the child's category having to do with school problems. Again, School Advocacy was the principal intervention and was coupled with counseling for the children. Category #7, caregiver seeks legal help for custody, guardianship or adoption was next with 22 responses. The encounters with county social workers were often adversarial and demoralized and frustrated the caregivers. It also impacted the children who feared they might be removed and placed back into foster care in non-Indian homes.
Court Advocacy coupled with liaison work with county social workers was the service provided.

Category # 11, caregiver overwhelmed by child(rens) needs, emotional, etc., with 19 responses was an important issue. By year two of the program the children had been in placement for a year or a good portion of a year. The problems with which the children came into the homes of the caregivers began to manifest and the caregivers found themselves overwhelmed. They were also overwhelmed by the challenges of having so many new additions to the family and all the adjustments this demanded in terms of additional resources and demands on the caregiver's time and energy. Category #4, caregiver lacks involvement with child's progress at school also had 19 responses and was a continuing problem. The other problems in the household oftentimes put success at school for the children low on the priority of the caregivers.

The remainder of the presenting problems for the caregivers were more individual in nature. Our staff developed treatment plans for all caregivers and appropriate services were provided to help alleviate or resolve the problems.

Categories of Family Presenting Problems
Categories of family problems were also important to us. Following are the presenting problems confronting them.

Categories of Problems	# of families with prob. Yr. 1	Yr. 2	Yr. 3	Totals
1. Poor communication & problem solving skills	7	7	10	24
2. Desire of family for permanence, guardianship	8	10	10	28
3. Family adjustment to new family members	4	5	5	14
4. Family has basic needs: food, shelter, health	12	10	12	34
5. Child fears removal from kinship family	5	4	6	15
6. Family grief work	6	7	5	18
7. Counseling for child requested by county social worker	9	9	6	24
8. Caregiver requests tutoring for children	6	4	3	13
9. Involve family in child's school success	10	12	12	34
10. Family threatened by parent	1	1		2
11. Family (grandparents) need senior services	3	4	3	10
12. Family requests support services	8	12	10	30
13. Family needs crisis intervention	5	7	5	17
Added Year 2				
14. Illness and health issues of caregivers & children		9	11	20
15. Family (caregivers) need respite care		7	14	21
16. Help family access community resources		7	8	15
17. Family needs help getting children to attend school on regular basis		5	3	8
18. Constantly changing make-up of household negatively impacts family cohesiveness		5	4	9
Added Year 3				
19. Family in unstable or unsuitable living conditions			6	6
20. Family life is chaotic needs help with daily routines, schedules, prioritizing, etc.			7	7
21. Family needs supportive services after caregiver loses source of income			3	3
22. Family needs help in including child in family activities			2	2

Family presenting problems were quite diverse. The two categories with the most responses were # 4, Family has basic needs for food, shelter and health care, with 34 responses and Category # 9, involve family in child's school success, with 34 responses. Category #4 was an on-going problem throughout the program. Poverty played a great role in causing set-backs to

families as they tried to stabilize. Staff remained sensitive to this situation and worked with families to find reliable resources to help alleviate some of the effects of grinding poverty. Category # 9, was involved in providing school advocacy and family counseling to help families understand why everybody needs to be concerned about the child's progress in school. Category #12, the family requests support services with 30 responses, reflects the need experienced by the families for the in-home support. Factors that prohibited caregivers and family from succeeding were: poverty, lack of reliable transportation, and lack of child care. Having staff provide the support services in-home was the most efficient and effective method for delivering the services.

The category with the next highest number of responses was # 2, desire of family for permanence usually in the form of guardianship with 28 responses. This category continued to be of concern throughout the 3 years of the program. With some families, it took the full 3 years to achieve permanence. The trips to court, the encounters with county social workers and adoption workers were filled with frustration. Oftentimes the encounters were adversarial. The caregivers felt defeated and on the verge of giving up. The children feared being removed and placed in foster care, group homes or juvenile detention.

Category # 1, poor communication and problem solving skills had 24 responses. Counseling was provided to children, caregiver and the family. Communication and problem solving skills were modeled in the in-home setting in order to teach the children, caregivers and family unity how to develop these skills. Category #8, caregiver requests tutoring for children had 24 responses. Referrals were made to the SCIC, tutoring program. Staff also followed the children's school progress, monitoring report cards and conducting regular meetings with school personnel. Category # 15, family (caregivers) need respite care had 21 responses. This was a service we felt would be important to maintaining placements. We provided more respite care than is indicated in the numbers. Although respite care was needed and important to families, they often identified other problems as those needing the most attention. Category # 6, family grief work had 18 responses and further underscores the thread of loss and grief that was woven throughout all of the work we conducted with the kinship care families we served.

All of the presenting problems were important—they were factors that could prevent a family from continuing to be kinship care providers and we developed treatment plans and provided services for all families. We mention some of them because of the number of families with similar problems and concerns. It is also important to remember that some children, caregivers and families had more than one problem that needed to be addressed concurrently. Some children, caregivers and families worked on the same problem throughout the 3 years of the program, while others identified problems in the first year that were resolved and went on to work on other problems in years 2 and 3.

1. Statement of evaluation question

The question was whether providing the already described array of services in a culturally competent manner would demonstrate the enhanced well-being of American Indian children,

their kinship caregivers and the family unit as a whole as compared to their well-being prior to program implementation.

2. Expectation for change

The expectation for change was that the children, their kinship caregivers and the family unit as a whole would experience enhanced well-being. This would be demonstrated by tracking their progress using a Likert Scale ranging from 1= case goal not met to 5= case goal met. (Please see copies of tracking forms in Appendix C.) Clients were given initial assessment of their status with the presenting problem at month 1 of their entry into the system with assessment continuing in month 6 and month 12 of each year they were in the program. Most children, caregivers and family units satisfactorily resolved presenting problems and moved on to working on resolution of other problems as they emerged. A small number of children, caregivers and family units worked on the same problems throughout the course of their stay in the program.

A. Findings that Relate to Outcome-related Research Questions

1. Report Findings (changes in scores, percentages, frequencies)

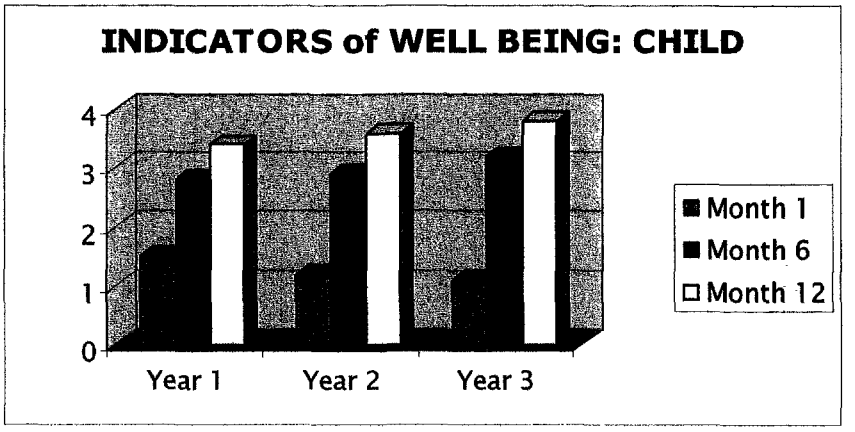

Figure 1

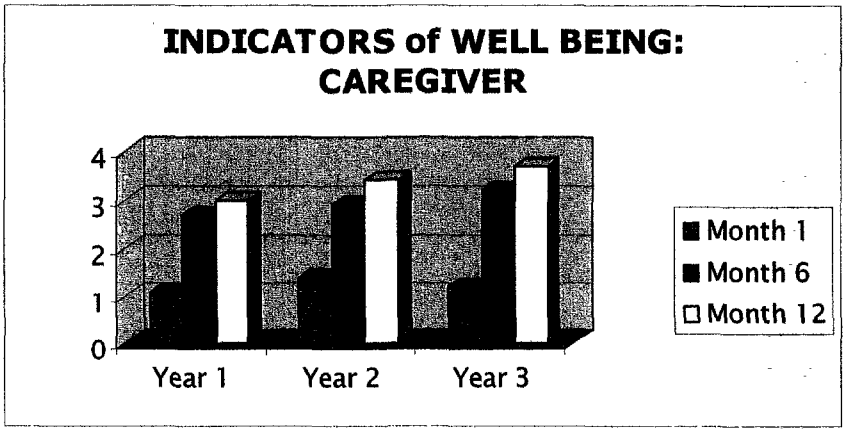

Figure 2

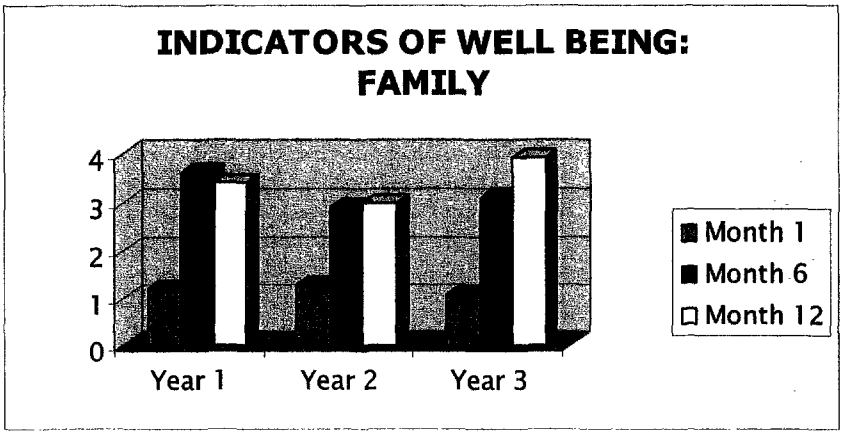

Figure 3

2. Issues that affected data collection/analysis

There were no significant issues that affected data collection or analysis.

3. Discussion of results

Figure 1 tracks children for each of the three years of the program. Figure 2 tracks kinship caregivers for each of the three years of the program. Figure 3 tracks the family, as a unit, for each of the three years of the program. Generally, the data reflects an overall trend showing progression towards the goal of enhanced well-being. At the beginning of each year children, caregivers and family units were working on new issues or were at a new starting point in working on issues from the previous year.

For each of the groups tracked, the greatest gains were made between months 1 and 6. Gains either continued, demonstrating improvement, or were held in months 6 to 12. Gains were greatest in year 3 for each of the groups, demonstrating increased maturity on the part of staff in making assessments, initiating an appropriate treatment plan and delivering needed and appropriate services and interventions.

4. Issues related to interpretation of results/rival hypotheses

We had no rival hypotheses and the interpretation of the results was straight-forward. Client progress was tracked using the Key Case Goal Forms, data was collated, analyzed and presented.

5. Lessons learned

What we learned in the course of providing services was that there were no spectacular instances of success. Every step of improvement was hard-won. There were many set-backs for children, caregivers and the family as a unit. The effects of extreme poverty, continuing loss and grief and unstable living conditions caused by lack of income and chaotic households due to the constantly changing make-up of the household often precipitated the set-backs. Oftentimes progress came to a halt when

the children, caregivers or the family were overcome by grief or illness or the death of a caregiver.

As indicated in Figures 1,2 and 3, by the time we reached the 3rd year our staff was becoming most effective in assessing, developing the treatment plan and initiating necessary and appropriate services. As expressed in our recommendations, a funding cycle of 5 years would have allowed for increased success with our clients.

The other lesson we learned is that we designed and implemented a program that contained the elements and components of service that are **right** for our unique population. We included non-traditional services and non-traditional delivery of services to enhance other more traditional services that were the core of the program. We also discovered that we needed to include a mentoring component for the children to help them in achieving success in school and to increase self-esteem, self-reliance, a positive self-image and positive identification with their cultural heritage.

CHAPTER IV. – USE OF PROGRAM IMPLEMENTATION DATA TO UNDERSTAND OUTCOMES

Discuss relationships between implementation of activities and participant outcome results.

a. Program components that appeared effective in fostering attainment of expected outcomes.

As has been mentioned before in this evaluation, Indian Child and Family Services designed the services offered to kinship caregivers based on a model developed over time by the Program Coordinator and the staff. Each of the services offers an important and necessary resource to first retrieve relative children from the child welfare system and then to keep them in a safe and stable placement where the child can grow and prosper and have a place where they "belong".

The following describes each component and why it was necessary and effective:

1. **Court Advocacy and Advocacy with Los Angeles Department of Children and Family Services (DCFS)** – ICFS staff provided the advocacy so that the grandparent could gain custody of the children and achieve permanency. Sometimes it was necessary for ICFS staff to align themselves with the court, other times with DCFS, whichever would achieve having the children placed with their grandparents or other relatives. Often times either the court or DCFS were opposed to the children being placed with the grandparents or other relatives for arbitrary reasons.

   Grandparents asked our staff to help them because they did not know how to advocate for themselves either with the court or DCFS. They often times would give up after a single try at gaining custody of the children. We worked with them on being persistent, modeled how to advocate for themselves and how to engage

others, such as the tribe, in helping them. In one case in particular, there was a child that an Auntie wanted to take into care. The DCFS worker went to the house and determined that there wasn't enough room for the child. One of our Native staff members contacted the child's tribe. The tribe's representative contacted the court, and, following the guidelines of the Indian Child Welfare Act, asked that the space requirement be waived. It was, and the child was placed with the Aunt.

Workers also taught the grandparents and other care givers how to write letters to schools, the court, the tribes and other agencies. On many occasions the written requests had excellent outcomes and grandparents and caregivers learned a valuable skill that they can continue to use.

2. **School Advocacy** – Many of the children came into the program with serious school difficulties. Many were below grade level and/or chronically truant. Grandparents or caregivers had no ability or experience in interfacing with the schools. Many did not know they could demand services for the children or report inappropriate or unhelpful behavior on the part of school personnel.

   ICFS staff accompanied grandparents to school and modeled for them how to advocate for the children. Staff also advocated for the children, forcing the schools to comply with state educational services requirements. Staff initiated Individualized Education Plans (IEPs) for those children needing special services. Staff attended school functions with the grandparents, once again modeling the importance for the grandparents of being involved in the child's educational life. The school functions attended featured the children and included, school plays, Back-to-School nights, teacher/child conferences and sporting events.

3. **Health Advocacy** – The unattended health care needs of Indian families continues to be a serious problem. This applies to our elderly caregivers and the children they took into care who came from situations of extreme poverty and neglect. Many of the kinship care providers we served in this project were raised on reservations where they had access to Indian Health Services (IHS) hospitals and clinics. They were unfamiliar with accessing health care in an urban setting. Their fear of non-Indian practitioners was a factor that further impeded their accessing of needed health services.

   Our Native Health Care worker assessed the families health care needs and assisted them in following through in attaining treatment both for themselves and the children. The Health Care worker accompanied the caregivers to doctor's and dental appointments, teaching them to be persistent in seeking treatment. The Health Care worker also worked with the families in being compliant with the taking of prescribed medications and other treatment. Because the worker was Native, she used a combination of western and traditional native approaches to healing and health practices.

4. **Counseling (Therapeutic Treatment)** – With all the families with whom we worked, before entering into a counseling/therapeutic relationship, staff spent time developing trust and rapport by providing supportive and other services. Staff moved slowly toward providing therapeutic counseling.

   Because of the approach, many clients, to whom "counseling" is a foreign concept, participated and benefited from treatment. Once families were engaged in the process, we experience that many of the caregivers and children needed to do grief work for both past and current losses. Most of the children were feeling the effects of abandonment by their parents. Another important component of counseling with the children was work on increasing their self-esteem and their sense of a positive cultural identity. Sometimes it was difficult to convince the grandparents or caregivers that the children might need counseling because they so completely accepted the children as they were. They thought the children were fine just as they were, not understanding that some of the behaviors might be inappropriate and something the children might need to work on in order to get along better within the family, at school and in other settings outside the home.

   Although individual counseling was provided much of it was with the whole family. There were situations where siblings, prior to kinship care placement, had picked on one another and fought with one another. There were also situations where the caregivers had children of their own and when the relative children were taken in to care they felt displaced. There was also the issue of the kinship children exhibiting disruptive behaviors both in the home and out of the home. The counseling services were important in stabilizing the families.

5. **Parent Education** – Many of our caregivers had been raised in government boarding schools. They were removed from their parents, their home, their reservation and all that was familiar to them and placed in settings that were regimented, where they were forced to wear military-like uniforms, had their long hair cut off and forbidden to speak their native language. Many of the caregivers, as children, suffered physical and emotional abuse. They did not learn appropriate parenting skills—which one learns by living at home in ones family.
   In addition to modeling good parenting behaviors in the home, our staff discussed positive Indian parenting techniques and gave hands-on training in using the techniques, including, time out, behavior modification, natural consequences, praising, and so forth. They also provided simplified written training materials for the caregivers to read. Health and safety training were part of the Parent Education component of the program. We provided smoke alarms, baby-proofing locks for the home, provided training on nutrition and good health practices.

6. **Recreational and Educational Services** – These services were provided to the children. The recreational outings were used to expand the children's experience of the world and to expose them to both Traditional Indian culture and to non-Indian cultural activities. Staff accompanied children to Pow-wows, introducing them to their favorite flute player, dancer, vendor or athlete and had them talk with

the children about their skill or talent. Increasing the children's knowledge of their culture helped in instilling pride in themselves and increased their self-esteem and self-confidence. In an effort to increase interest in school and school subjects, the children were taken to museums, libraries and on educational field trips to the aquarium and the planetarium. They were also taken on nature walks. Many of the children experienced marked improvement in school.

Respite Care for the caregivers was a by-product of the Recreational and Educational services for the children. The grandparents and other caregivers got time off from parenting. Sometimes this was only a few hours, other times it was a full day on a week-end. All the caregivers expressed that they benefited from the break from parenting.

Staff also provided respite care for caregivers experiencing family emergencies or needing to go to appointments.

7. **In-home support** was the most used service and the one that seemed most effective to our families in their achieving their goals. Our team made regular visits to the home giving staff the opportunity to constantly reassess the needs of the family and to adjust the treatment plan to changing needs. Staff members were able to model appropriate parenting skills in a safe and familiar setting. They were also able to closely observe family dynamics, and changes to the make-up of the family, identifying those changes that could signal danger to the child in placement thus averting disruption. The in-home services allowed for staff to monitor the suitability of the home environment in terms of cleanliness, safety hazards, and other factors that might cause the child to be removed. Health of the children and caregivers was also monitored and help was given to families in locating and accessing resources.

   Individually, the services benefited those receiving the services. The services were designed, though, as pieces of a whole. When families received one or more of the services, we saw a marked improvement in the family's functioning leading to increased stability and permanency for the children.

b. Program policies, practices, or procedures related to implementation that appeared effective in fostering attainment of expected outcomes.

There were six program policies and/or practices that we felt were particularly effective in fostering attainment of expected outcomes. These follow.

1. A program policy and practice of ICFS that was effective in fostering attainment of expected outcomes was that of conducting weekly case staffing in combination with clinical supervision provided by a Licensed Clinical Social Worker. This practice insured that all members of the team working with a family were aware of current happenings in the family and any changes to the case plan.

2. Another practice of the agency was that when working with the families we used a staff team approach. Depending on the problems or issues within the family the team might consist of any of the following:
    i. a therapist, Native or non-Native (all licensed);
    ii. a Health Worker (Native); and,
    iii. a caseworker/advocate, Native or non-Native.

3. The practice of providing for practical needs of a family were also effective in fostering attainment of expected outcomes and goals. We found we could not get to working on other issues until the family had necessary goods, money, clothing, and bus tokens. We also provided Christmas and birthday gifts for the children, purchased school supplies, school uniforms, provided tickets to movies, ice skating, sporting events, bowling and boat cruises in the harbor when the family did not have funds to provide these activities or goods.

4. One of the activities for the children was taking them to nice restaurants, (Denny's, Carrow's, Coco's) for lunch. The purpose was to teach the children that when one learns, one earns and one can enjoy what one can afford. This was one reason for children to stay in school and learn all they could. It provided motivation. It also provided an opportunity to teach table manners, explore eating foods different from what one eats at home, and have a one-on-one conversation with an adult.

5. The practice of providing services in the home was effective. It allowed us to see family dynamics and helped us stop unsafe practices before children were endangered. It also allowed us to model appropriate parenting and other behaviors in the family setting.

6. Staff worked non-traditional hours including after 5 pm and week-ends when needed. This flexibility allowed for conducting recreational and educational activities for the children. They were also available for evening school meetings or for emergencies.

c. Staff characteristics/project components that appeared effective in fostering attainment of expected outcomes.

Staff characteristics that appeared effective in fostering attainment of expected outcomes were varied. First, the program made every effort to hire Native workers with the proper education, licenses and credentials. In those cases where Native workers did not apply or were not qualified, non-Native workers, usually from ethnic minorities, were hired. These workers were familiar with the Native population in Los Angeles area and with Native customs and traditions.

As mentioned in section "b", our staff worked in teams. The Native workers took the lead in establishing the sense of trust and establishing rapport with the families.

Native staff then introduced the non-Native staff to the family. This was done over a period of time so that all felt comfortable with one another.

Staff working in this program needed to have the characteristics of flexibility and creativity. They needed to be able to work as part of a team with both professionals and para-professionals working on an equal footing. Staff needed to be able to work collaboratively with staff from other agencies and providers. Staff needed to be able to do whatever was necessary to meet the needs of the family goals. For example in order to help families maintain children in the home staff provided the following services:

We had a family where the caregiver, an elderly Aunt, had cancer and had undergone radiation and chemotherapy. She was unable to care for the children. Two of the Native professional staff (therapists), suggested to the Program Coordinator that practical services to the family were needed and in order. They volunteered to go to the home and clean. They cleaned ceilings, walls, floors, and greasy stove and washed weeks worth of dirty laundry. After a thorough cleaning of the home, including doing pest control to eliminate roach infestation, they also purchased groceries and stocked the refrigerator and pantry with food. They also purchase school clothes for the children. They continued these untraditional services until the caregiver was able to resume those responsibilities. Without this intervention the children would have undoubtedly been removed by DCFS.

Another important characteristic of staff is that they had to be willing to drive in an urban area covering 5,000 square miles to provide the in-home services. They also needed to be willing to work untraditional hours, i.e., after 5 pm and week-ends.

CHAPTER V. –RECOMMENDATIONS FOR FUTURE POLICES, PROGRAMS, AND EVALUATIONS (BASED ON EVALUATION RESULTS AND LESSONS LEARNED)

A. Recommendations to Program Administrators

We found that the Children's Bureau made our work easier. We appreciated the semi-annual financial and program progress reporting. We found communicating with Bureau personnel to be efficient either through e-mail or on the phone. Response to our questions and concerns was always timely.

The annual grantees meeting provided us with all the information we needed in terms of the technical implementation of our proposals, i.e., cash flow, reporting, evaluation and any other questions that came up.

The grantees meeting also allowed for us to hear what other programs were doing, learn of any new trends in our field that might be important in how we conducted our work, and introduced us to people or programs we could contact with questions or to gain information. Generally, we appreciated hearing of other program's successes, frustrations and how they were doing

in implementing their programs. There was a feeling of fellowship at the meetings that was uplifting to those of us who attended and allowed for us to continue our work with enthusiasm.

Our recommendation is that the Children's Bureau continue in their already successful efforts to streamline reporting and the technical aspects of implementation and that the grantees meetings also continue.

B. **Recommendations to Program Funders**

We recommend that Program Funders continue and increase funding for Kinship Care and permanency services and foster care and adoption recruitment services, especially for minority populations. We further recommend that new cycles of funding be for 5 year periods rather than two or three. We also recommend that the funding be a stable number for the duration of the funding cycle. For example, if a program is funded for $300,000.00 per year, that the amount not be decreased for subsequent years.

Kinship Care fulfills an important function. It saves the counties, states and federal government money. It is less expensive than foster care. It makes better lives for children because they are out of the foster care system and in more stable and permanent placements with family. Kinship care keeps children from bouncing around from foster care placement to foster care placement and from being placed in increasingly more restricted placements, from foster home, to group home and oftentimes to mental health or juvenile corrections institutions. By being placed in kinship care, children are not further traumatized and don't suffer added loss and grief.

C. **Recommendations to Adoption Field**

We recommend that the adoption field look closely at the Indian Child Welfare Act and its requirements and make increased efforts to insure compliance. We also recommend that the adoption field recognize that Indian tribes and families do not believe in, value, or have as a cultural norm the sundering of the parent/child relationship. Mainstream practice in the field of adoption requires "relinquishment" of infants and children or "termination of parental rights" before adoption can occur. We recommend that the adoption field familiarize itself with and adopt as an option for Indian child adoptions the practice of "Customary Adoption".

The National Indian Child Welfare Association (NICWA) based out of Portland, Oregon has done extensive work in the area of customary adoption. They have worked with the Indian Law School program at the University of New Mexico to draft, for tribes' use, Tribal Codes governing Indian child adoptions. Please see a handout provided by NICWA in the appendix section at the end of this report. NICWA also can be contacted for further information.

We recommend that the adoption field, when working with Indian families, especially those in kinship care situations, refrain from demanding that those families adopt their relative children and cease to use adoption as the only option for permanency. Most Indian families will take guardianship of relative children in their care. For these Indian families guardianship offers the same permanency as adoption would in non-Indian families. Our experience over the last three years in implementing the Kinship Care program has demonstrated in numerous situations that county social workers and adoption workers continue to be ignorant about Indian customs, refuse to listen when those who are familiar with them try to advocate for Indian families and continue to threaten disruption of kinship care families in the name of "permanence".

We respectfully request and recommend that the adoption field acknowledge that adoption is not the only permanence option. We further recommend that the mainstream adoption field acquaint itself with those solutions to the caring for of Indian children who have been abandoned, orphaned, or whose parents are deemed unfit to raise them that the Indian community has traditionally used, namely, customary adoption.

APPENDIX A. - EXAMPLES OF SUCCESSES

Success Stories

Alicia: This kinship care family consisted of the maternal grandmother and her husband, and children who are placed with them—Alicia, Alicia's half brother Robert and cousin Jack. Alicia, whose mother was a heroin addict was placed with her maternal grandmother after her mother was incarcerated for drug use. When we began work with her Alicia was ever hopeful that her mother would get better and take her back. She was having difficulties in school, unable to concentrate and daydreaming. She was performing poorly in her classes. Alicia received counseling for the entire period of this grant. We worked with her on grief issues having to do with the loss of her mother and also worked with her on the problems she was having in school. At the end of the program Alicia was performing at grade level and doing well in school. She has also gained some recognition and acceptance that her mother probably will not be able to raise her and that her permanent home will be with her grandparents.

April: Her paternal grandmother raised this child until her grandmother's death about three years ago. She then went to live with a paternal aunt. Her aunt and uncle requested services because she was having trouble in school. She received counseling for all three years of the grant. The primary issue was related to grief and loss of her grandmother through death, her mother through abandonment, her siblings through the foster care system, and a sixth grade friend through suicide. She also didn't know which of two men was her actual father as revealed by her mother. She disclosed in counseling that she knew she had two other younger sisters whom she had only met once. She was afraid that these girls would not remember her. She also knew she had other siblings living with other relatives.

Through counseling April was able to discuss her many losses and to go through a grieving process for her grandmother. Using our school and educational advocacy services, staff working with April and her aunt and uncle helped get her transferred to a school that had an Indian Education program. At her new school, school personnel took an interest in her. While in the process of providing services to April and her aunt and uncle, they went through a separation, her aunt was evicted from her home when her husband moved out and the aunt had to have surgery on her arm, incapacitating her for a while. While all these events were transpiring, April continued with her counseling, her schoolwork turned around and she became an A and B student.

Jim: When we began working with Jim's grandparents they were working toward having him moved from a group home and placed with them in their home. They were successful in their endeavors. At the time of this placement he was on medication to control his behavior and needed special education. He also had numerous physical problems including a deformed foot. Our staff worked with the grandparents to set up and maintain a system of behavior modification and to help them access community resources. We worked with this family for three years and they continuously learned new ways to cope with his behaviors. Although he was very disruptive to the family, they have been able to maintain him in the home on a much reduced level of medication. Jim also gained the ability to function better in the classroom. A

big part of our worked included coordinating community resources. The grandparents were also raising Jim's two older cousins and helping to house several of their own adult children.

In the families mentioned above, and with all the families with whom we worked, there were many stressors impacting the families making it difficult to gain stability. Some of these stressors were:

- Death of a child
- Death or illness of caretakers' parent
- Catastrophic Illness of caretaker
- Death of caretaker
- Eviction from home
- Divorce or separation of caretakers
- Loss of job
- Other relatives moving in to already crowded home
- Negative or destructive relationship with county social worker
- Family relocating within the city, new schools, new friends.

The important thing to remember with these children and with all the children that we served is that no matter the stresses and difficulties the families were having and the disruptive behaviors with which the children came, the families did not give up and the families did not ask to have the children removed. Our experience and that of most private and public agencies working with foster parents, is that once children begin to act out and exhibit disruptive behaviors, the foster parents ask to have the children removed. Had these children been in foster care and not placed with relatives they would have been moved from place to place exacerbating the behavioral issues.

APPENDIX B. - TECHNICAL APPENDIX (DETAILED METHODS SECTION)

The methods used to gather data were as follows. A meeting was held with two staff from James Bell Associates to help us develop the evaluation plan and the instrument used to track progress for clients of the kinship care program. The instrument is based on the Likert Scale. Please see copies of each of the instruments developed for the child, the caregiver and the family. Staff working with the families completed these instruments. They document progress on a yearly basis beginning with Month 1, again at month 6 and at month 12. There is also a final evaluation of progress used when services to a family ended. Many of the children and families were served for the entire 3 years of the program. In most cases progress was tracked for the presenting problem. In subsequent years, the problems changed and progress was tracked in resolving those problems. For example, grandparents would come into the program seeking court advocacy services in an effort to gain custody of their grandchildren who were in the foster care system. Because of the resistance of county social workers to placing children with their grandparents, this advocacy could be lengthy lasting for months. Once this initial problem was resolved and the children were in placement, the grandparents would seek school advocacy because the children were experiencing difficulties in school. In the course of providing services the children would enter counseling to work on loss and grief issues that were spilling over into their school life. This pattern was not unusual as we worked with the families.

We also developed two additional forms that can also be found in the appendix. One is called "Services Provided". It was filled out by the worker or the Program Coordinator and listed the services each family used. It also documented Final Disposition for a case letting us know why services were terminated. We also documented the Legal Status of the children, whether they were adopted, went into legal guardianship, were in an informal kinship care placement where the court was not involved. We also gathered information on whether any of the kinship care placement were disrupted, how many children were involved and where the children went, either back to the Tribe, back into the county foster care system, or some other arrangement. We also documented the number of months each family was served.

The second form we developed was a demographics form. It was used to describe the composition of the kinship care family, asking for date of entry into the program, names of caregivers, their tribal affiliation, gender and age. The information we gathered for the children included their name, date of birth, age, tribal affiliation, gender, and relationship to the caregiver. We also asked for the address and home phone of the caregivers.

These data collecting instruments are the basis for the data we have gathered, analyzed and reported in this final evaluation.

Because our practice was to use a team approach in providing services, the staff member working with each family member completed the forms. The form for the child might be filled out by the therapist providing counseling, the form for the caregiver might be filled out by the caseworker/advocate providing health and court advocacy services and the family form might be filled out by the therapist and the caseworker/advocate.

Although the intention at the beginning of the program was to complete the Key Case Goal forms every 6 months, we discovered that progress could be better monitored on a yearly basis. Progress was often slow and often children, caregivers and family took one step forward and two steps back until stability and continued work with them began to show forward progress.

Data was gathered on an on-going basis throughout the program cycle. The consultant hired to conduct the final evaluation met with the Program Coordinator and the staff on a regular basis to insure data collection forms were being completed, to discuss problems that might be occurring in gathering the data and to resolve those problems. Data from the first year was collated in the second year and shared with the staff and Program Coordinator. The data indicated that the services being provided were proving effective in moving children into kinship care and that stable placements were developing.

This information was valuable to the Program Coordinator in that no adjustments needed to be made to the service array designed and few adjustments to how the services were delivered.

At the end of the program all of the completed data was gathered and examined for completeness. In those cases where data was incomplete, the evaluator, the Program Coordinator and staff met to conduct interviews and chart reviews to complete data forms. The evaluator then examined, collated, extracted data, analyzed the data and developed this report in consultation with the Program Coordinator.

It is important to note that this program was designed in such a manner that we could not use a control group—one receiving services and one not receiving services and then comparing progress and success of one group to another. In a community such as the one with which we were working, where trust issues are so difficult to overcome, a program design using a control group would have failed. Clients would not use services parceled out in such a, to them, arbitrary and unfair manner.

Indian Child and Family Services
Kinship Care Program

Demographics Form

Date Of Entry: ______________________

Caregiver Name: ____ Age: ________
Tribal Affiliation: ____
Gender: (Check one) ☐ Male ☐ Female

Caregiver Name: ____ Age: ________
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Child's Name: ________________________________ DOB: __________ Age: _______
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Child's Name: ________________________________ DOB: __________ Age: _______
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Child's Name: ________________________________ DOB: __________ Age: _______
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Child's Name: ________________________________ DOB: __________ Age: _______
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Child's Name: ________________________________ DOB: __________ Age: _______
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Child's Name: ________________________________ DOB: __________ Age: _______
Tribal Affiliation: _________________________ Relationship to Caregiver: ____________
Gender: (Check one) ☐ Male ☐ Female

Address: ____
City: ______________________ State: _______________ Zip: __________________
Home Phone: ______________________ Other: ____________________________

Kinship Care Program
Services Provided

Client Name: _____ ICFS' Worker: _____

Please check box net to service. Check as many as were provided to this family.

- ☐ Counseling
- ☐ In-home Support
- ☐ Court Advocacy
- ☐ School Advocacy
- ☐ Referrals for services not provided by ICFS – what are they? _____
- ☐ Modeling Parenting Behaviors (parenting skills)
- ☐ Recreational Activities
- ☐ Day-time Respite
- ☐ In-home parent training
- ☐ In-home health & safety assistance
- ☐ Other – what service? _____
  (i.e., purchase clothes for children, take to Dr.'s appt., financial assistance, etc.)

Final Disposition: When case was closed what was the reason? (Check one box.)

- ☐ Family no longer needed services
- ☐ Family moved out of area
- ☐ Other – State what _____

Legal Status of Children (Check one box.)

- ☐ Adoption
- ☐ Legal Guardianship
- ☐ Informal Placement (court not involved)

Were there any kinship placement disruptions?

- ☐ Yes
- ☐ No

If yes, how many? _____

Where did children go?

- ☐ Back to Tribe
- ☐ Back into County foster care system
- ☐ Other – Where? _____

Number of Months services were provided _____

INDIAN CHILD AND FAMILY SERVICES
AMERICAN INDIAN KINSHIP CARE PROGRAM

KEY CASE GOAL: CHILD

Child's Name: _____ Date: _____

Caregiver: _____

Family: _____

Review: ☐ Initial ☐ 3 mos. ☐ 6 mos. ☐ 9 mos. ☐ 12 mos.

Data Sources

☐ Chart Review ☐ Staff Interview ☐ Other: School, CSW, Etc.

KEY CASE GOAL: DESCRIPTION:

_____

_____

INDICATOR OF CASE GOAL SUCCESS

Month 1

1 ——————2——————3——————4——————5

1=case goal not met 5=case goal met

Month 6

1 ——————2——————3——————4——————5

1=case goal not met 5=case goal met

Month 12

1 ——————2——————3——————4——————5

1=case goal not met 5=case goal met

Final

1 ——————2——————3——————4——————5

1=case goal not met 5=case goal met

Staff Name: _____ Staff Name: _____

INDIAN CHILD AND FAMILY SERVICES
AMERICAN INDIAN KINSHIP CARE PROGRAM

KEY CASE GOAL: CAREGIVER

Child's Name: _____ Date: _____

Caregiver: _____

Family: _____

Review: ☐ Initial ☐ 3 mos. ☐ 6 mos. ☐ 9 mos. ☐ 12 mos.

Data Sources

☐ Chart Review ☐ Staff Interview ☐ Other: School, CSW, Etc.

KEY CASE GOAL: DESCRIPTION:

_____

_____

INDICATOR OF CASE GOAL SUCCESS

Month 1

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Month 6

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Month 12

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Final

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Staff Name: _____ Staff Name: _____

INDIAN CHILD AND FAMILY SERVICES
AMERICAN INDIAN KINSHIP CARE PROGRAM

KEY CASE GOAL: FAMILY

Child's Name: _____ Date: _____

Caregiver: _____

Family: _____

Review: ☐ Initial ☐ 3 mos. ☐ 6 mos. ☐ 9 mos. ☐ 12 mos.

Data Sources

☐ Chart Review ☐ Staff Interview ☐ Other: School, CSW, Etc.

KEY CASE GOAL: DESCRIPTION:

_____

_____

INDICATOR OF CASE GOAL SUCCESS

Month 1

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Month 6

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Month 12

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Final

1 ——— 2 ——— 3 ——— 4 ——— 5

1=case goal not met 5=case goal met

Staff Name: _____ Staff Name: _____

NICWA Publishes Manual on Tribal Customary Adoption

The National Indian Child Welfare Association (NICWA) with the technical assistance of the American Indian Law Center, Inc. (AILC) has developed a manual on how to develop a tribal adoption code based on tribal customs and values. This manual includes a model code and incorporates, for the first time, a judicial process for the recognition and certification of customary law regarding the adoption of children. It also sets out a culturally based, conceptual framework for conducting formal adoptions without termination of parental rights. Whether or not to formulate either or both of these concepts into law is a landmark policy decision for tribes and represents one of the most important exercises of sovereignty that a tribe can undertake. This manual is designed as a guide to help tribes understand the issues surrounding customary adoption and to work through this process.

The model code was born of necessity and is one potential solution to a complex set of problems affecting Indian children, families, and tribes today. Increasingly, federal law and policy have expressed a clear preference in the child welfare system for termination of parental rights and adoption for children that cannot return to their own biological families. This is in direct conflict with the teachings of many tribes. Interestingly, almost every American Indian tribe has customs associated with adoption, so it is not a foreign concept. In fact, in surveying tribes, we have yet to find a tribe that does not have current or historical customary processes for adoption. None, however, have expressed customs that are equivalent to termination of parental rights. While it is safe to assume that it probably did happen, we could not find ceremonies, rituals, or common practices that ended relationships between parents and children. Other means are seen as appropriate for achieving permanency.

The manual makes a clear statement that the legal approaches set forth are untested. They represent a stance on tribal sovereignty that boldly claims permanency for children as a tribal value while implementing it in a unique and culturally specific fashion. We believe that this document represents a balanced approach.

Dissemination of and training events on the manual are being is being supported by The National Association of Adoption Exchanges under the

AdoptUSKids collaborative, which is funded by the Children's Bureau, U.S. Department of Health and Human Services.

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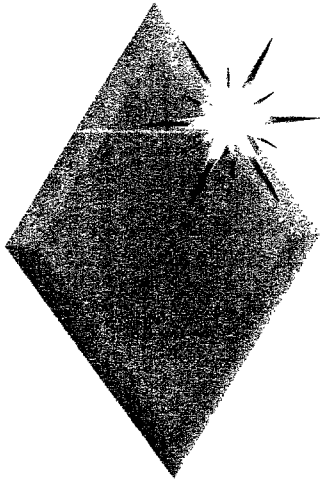
APPENDIX E. - PRINTOUT OF POWER POINT PRESENTATION USED FOR RECRUITMENT AND INFORMATION

Indian Child and Family Services
Kinship Care Program



A Program Of:

Southern California Indian Center, Inc.

The Kinship Care Program

- Provides support services to caregivers who are raising relative children

Services Available To The Kinship Caregiver

- Counseling Services
  (Therapeutic Treatment)

Services Available To The Kinship Caregiver

- In-home support

Services Available To The Kinship Caregiver

- In-home health & safety checks

Counseling Services (Therapeutic Treatment)

- Individual treatment for the child

Trained professionals provide counseling for the child either in the home or at the office. Treatment may include play or art therapy.

Counseling Services (Therapeutic Treatment)

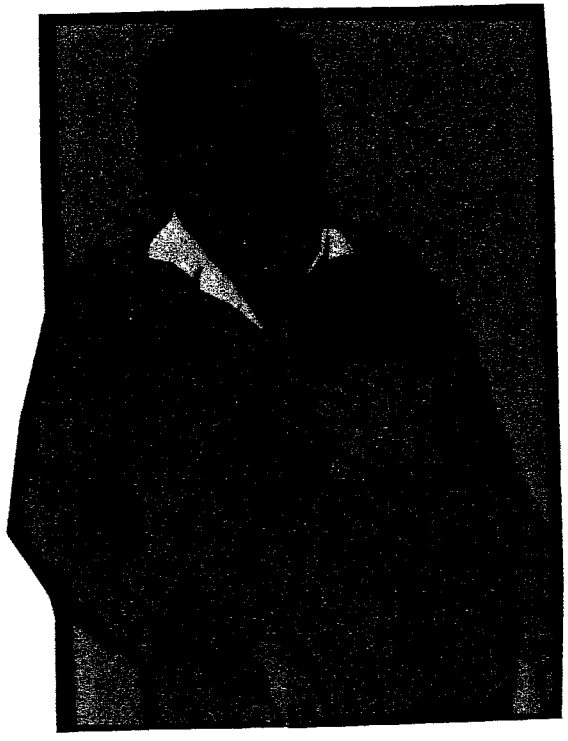
- Individual treatment for the caregiver

Trained professionals will provide treatment for the caregiver(s) in the home or in the office depending on the needs of the caregiver and the family.

Counseling Services (Therapeutic Treatment)

- Conjoint sessions (child and caregiver)

  Conjoint sessions with the child and caregiver will be provided to further treatment progress.



Counseling Services (Therapeutic Treatment)

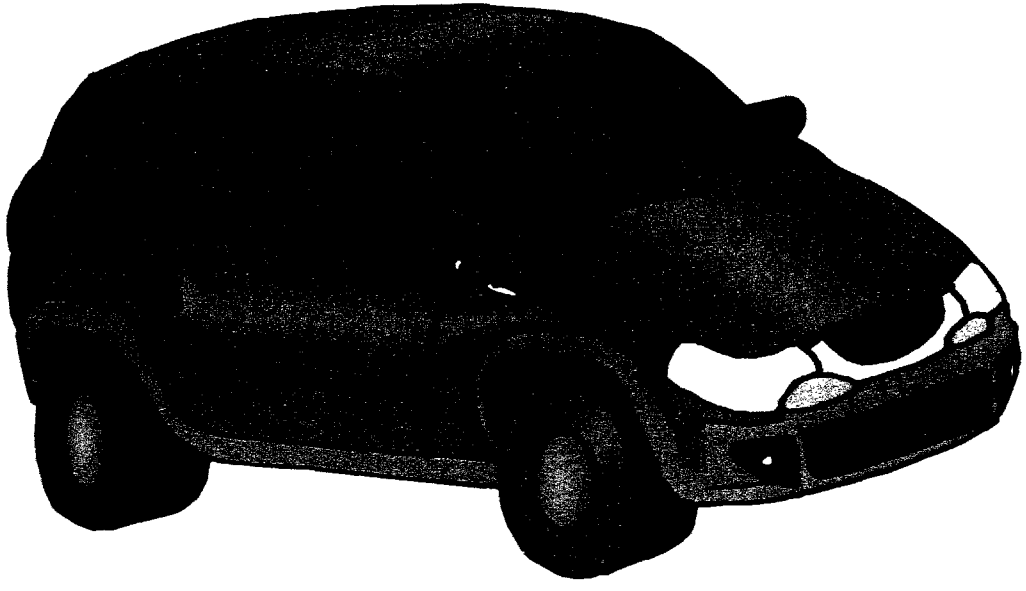
- Family counseling

The trained professional will provide family counseling, that can help resolve problems and allow all family members to be heard.

Court Advocacy

- Transportation to court

  Staff will provide transportation to court when caregiver cannot provide.



Court Advocacy

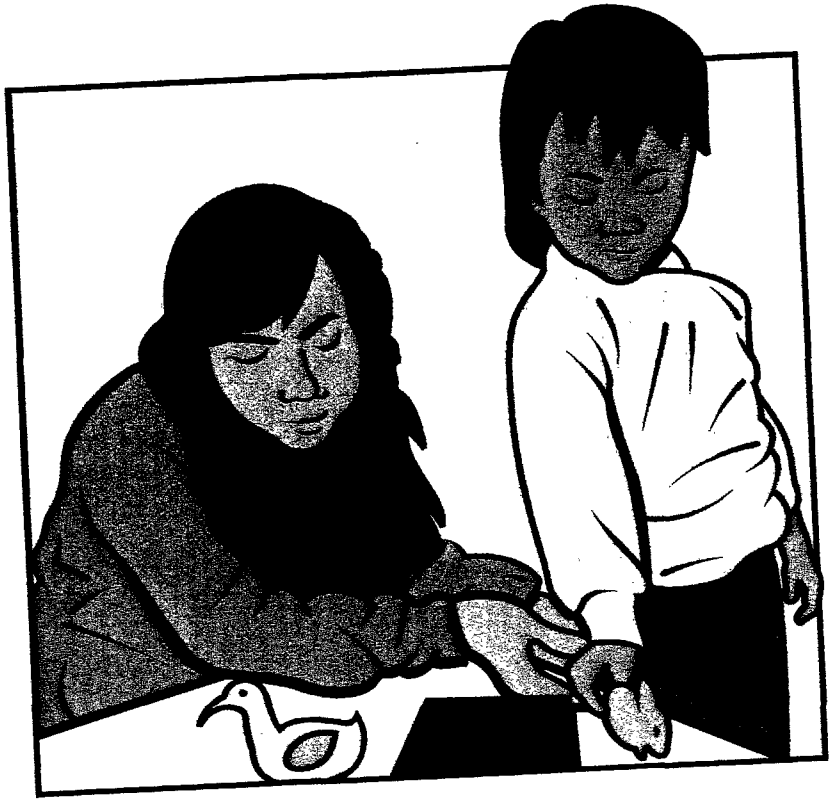
- Client support while at court

Staff will accompany caregiver and child to court hearings.

Court Advocacy

- Childcare while at court

  Staff will care for child while caregiver is in court.



Court Advocacy

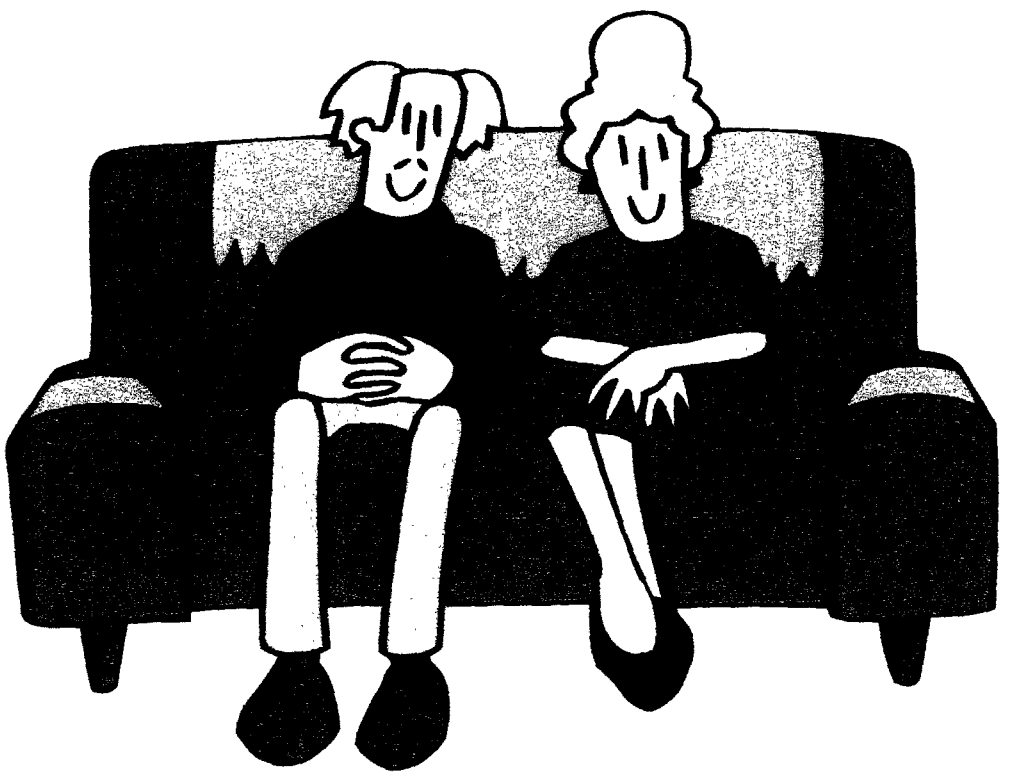
- Staff will serve as liaison between family and court officers including attorneys

Court Advocacy

- Staff will assist family to obtain additional legal assistance as needed

In-home Support

- Weekly in-home visits



In-home Support

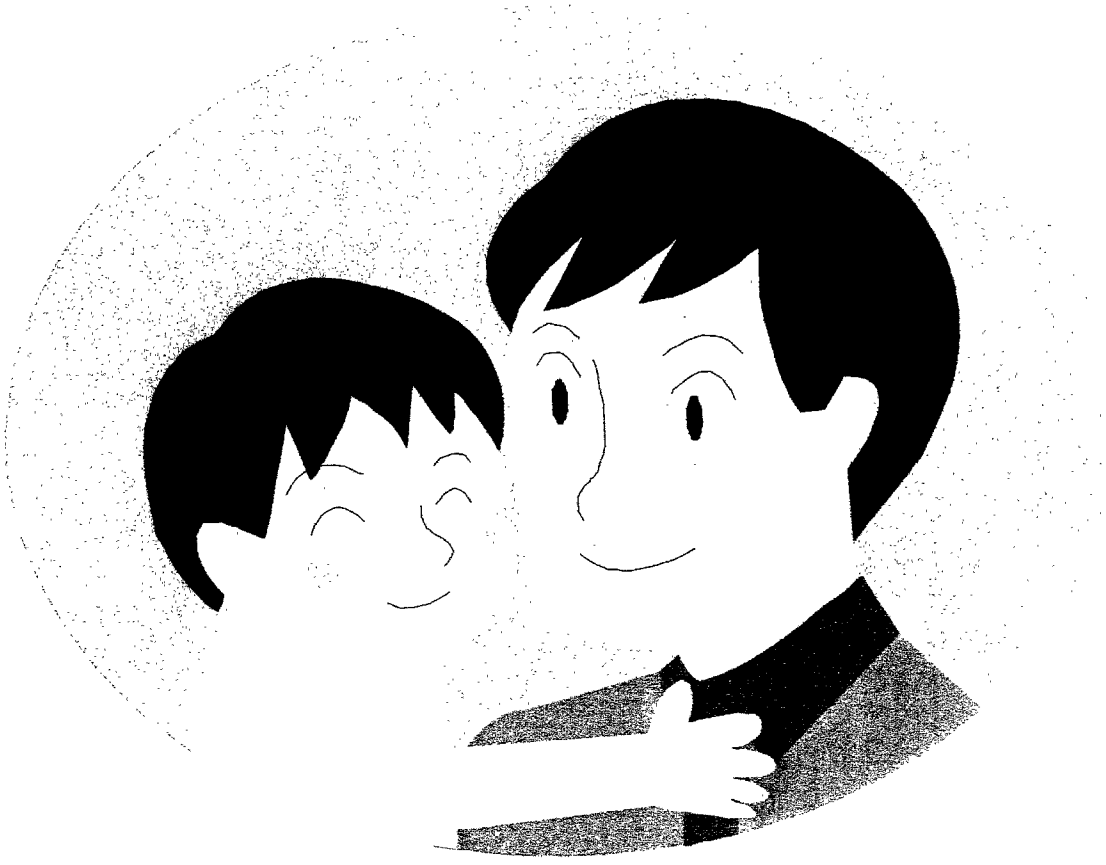
- Educational advocacy

In-home Support

- Medical advocacy

In-home Support

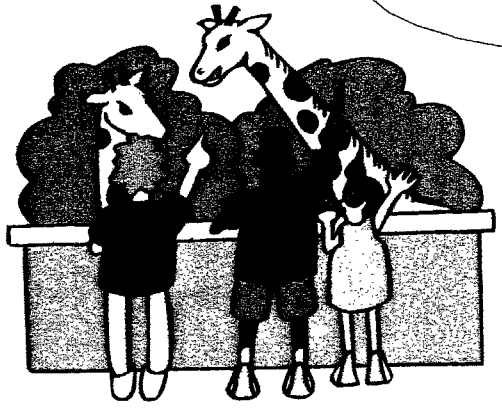
- Modeling good parenting behaviors

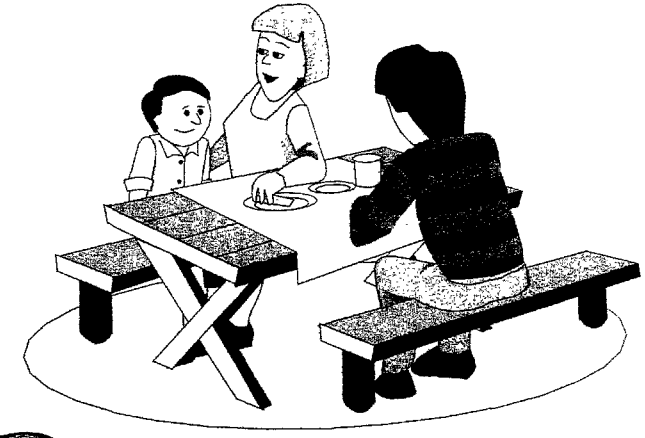


In-home Support

- Recreational Activities For Children

Staff will take children on therapeutic recreational & cultural activities





In-home Support

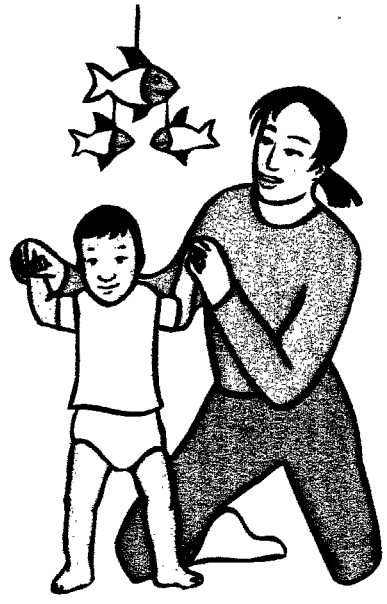
- Respite For Caregiver

  The therapeutic recreation also gives the caregivers time to themselves.

In-home Support

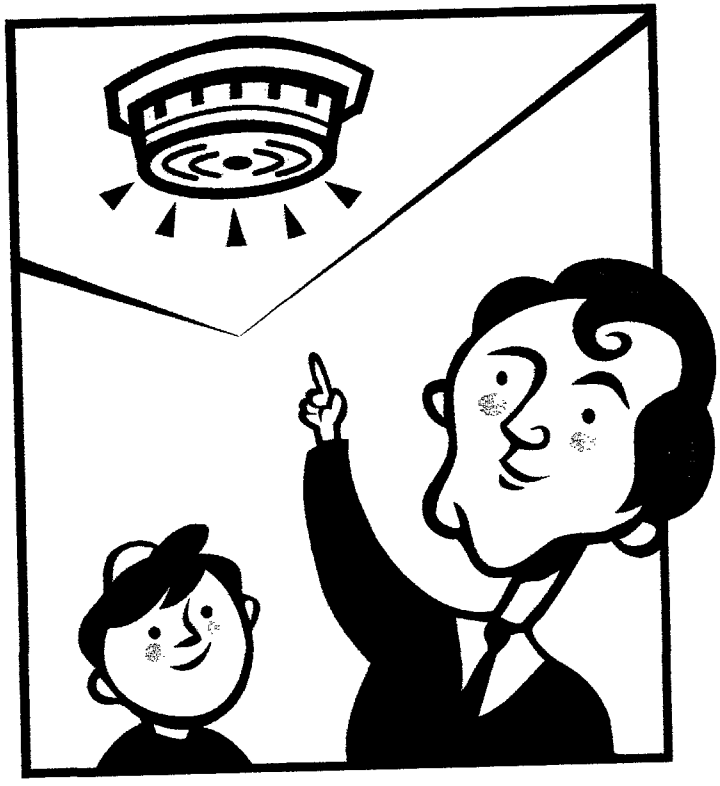
- In-home parent training

  Trained staff will work with caregivers on child development, behavior management, and other issues important to the caregiver and child.



In-home Support - Health and Safety Checks

- Staff will check home to insure it is safe and has:
- Smoke and fire alarm



In-home Support - Health and Safety Checks

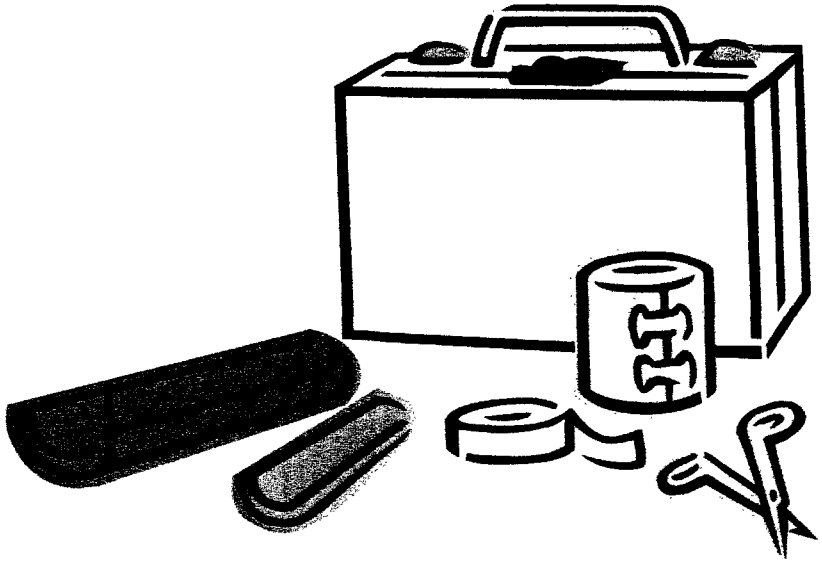
- Fire extinguisher

  Staff will check to insure fire extinguisher is proper type and is properly charged.

In-home Support - Health and Safety Checks

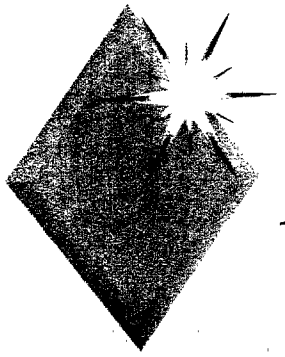
- First-aid kit

  Staff will check first-aid kit to insure it is complete and adequate for the family's needs.



In-home Support - Health and Safety Checks

- Home is clean and free of hazards



How To Get Services

If you are caring for a relative child or children, such as a grandchild, niece or nephew, cousin, brother or sister—call:

(213) 387-5772

and ask to speak to a staff member about the Kinship Care Program.

You may also stop by our office at:

3440 Wilshire Blvd., Suite 914

Los Angeles, CA 90010

SOUTHERN CALIFORNIA INDIAN CENTER, INC.

Indian Child and Family Services

3440 Wilshire Blvd., Suite 904, Los Angeles, CA 90010-2212
(213) 387-5772 - FAX (213) 387-1243
e-mail: icfs@earthlink.net

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Sandra Chase
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January 28, 2004

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James Bell Associates
1001 19th Street, North, Suite 1500
Arlington, VA 22209

Enclosed please find our Final Evaluation for the American Indian Kinship Care Program. I want to take this opportunity to thank the Children's Bureau, Administration on Children, Youth and Families for the opportunity to conduct the American Indian Kinship Care Program in Los Angeles, California. There is great need in this large urban setting for programs serving American Indian kinship caregivers and the relative children they take into care.

We at ICFS felt the three years of this program were over only too quickly. We appreciated the ability to conduct the work we did and found ourselves grateful for the opportunities presented to us through this grant. The families we served are some of the poorest in the country. The grandparents and other adult kinship caregivers with whom we worked have many needs and yet we found an underlying strength and the determination and the will to care for their minor relatives. Through advocacy and

training, we were able to teach caregivers how to get the services they needed. The children who came into their care benefited from being in a stable and permanent placement. The grandparents and grandchildren formed "family" and for many of them this particular road was filled with almost overwhelming loss and grief. For the children, loss of their parents to drugs, alcohol and homelessness, for the grandparents their loss of adult children and other grandchildren who were somewhere in the foster care, or juvenile criminal system. The ability of grandparents and grandchildren to overcome so many negative experiences and to come to a place where they were secure, safe and happy with one another was a great accomplishment. This would not have been possible without funding from the Children's Bureau.

It is our sincere hope that funding for kinship care will be made available again in the future and that our evaluation report may prove to be a resource for other Indian programs seeking to provide similar services in their communities.

We wish to thank you for your support and your timeliness in responding to our concerns and questions as we conducted the work of the American Indian Kinship Care Program.

Sincerely,

Kathleen Bridgeland

Kathleen Bridgeland, LCSW
Program Coordinator

Rose-Margaret Orrantia

Rose-Margaret Orrantia, MS
Program Evaluator